

PART 146—REQUIREMENTS FOR THE GROUP HEALTH INSURANCE MARKET

SOURCE: 62 FR 16958, Apr. 8, 1997, unless otherwise noted.

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AUTHORITY: Secs. 2702 through 2705, 2711 through 2723, 2791, and 2792 of the PHS Act (42 U.S.C. 300gg-1 through 300gg-5, 300gg-11 through 300gg-23, 300gg-91, and 300gg-92).

Subpart A—General Provisions

§ 146.101 Basis and scope.

(a) *Statutory basis.* This part implements the Group Market requirements of the PHS Act. Its purpose is to improve access to group health insurance coverage, to guarantee the renewability of all coverage in the group market, and to provide certain protections for mothers and newborns with respect to coverage for hospital stays in connection with childbirth. Sections 2791 and 2792 of the PHS Act define terms used in the regulations in this subchapter and provide the basis for issuing these regulations, respectively.

(b) *Scope.* A group health plan or health insurance issuer offering group health insurance coverage may provide greater rights to participants and beneficiaries than those set forth in this part.

(1) *Subpart B.* Subpart B of this part sets forth minimum requirements for group health plans and group health insurance issuers offering group health insurance coverage concerning certain consumer protections of the Health Insurance Portability and Accountability Act (HIPAA), as amended, including special enrollment periods, prohibiting discrimination against participants and beneficiaries based on a health factor, and additional requirements prohibiting discrimination against participants and beneficiaries based on genetic information.

(2) *Subpart C.* Subpart C of this part sets forth the requirements that apply to plans and issuers with respect to coverage for hospital stays in connection with childbirth. It also sets forth the regulations governing parity between medical/surgical benefits and mental health benefits in group health plans and health insurance coverage offered by issuers in connection with a group health plan.

(3) *Subpart D.* Subpart D of this part sets forth exceptions to the requirements of subpart B for certain plans and certain types of benefits.

(4) *Subpart E.* Subpart E of this part implements requirements relating to

group health plans and issuers in the Group Health Insurance Market.

(5) *Subpart F.* Subpart F of this part addresses the treatment of non-Federal governmental plans, and sets forth enforcement procedures.

[62 FR 16958, Apr. 8, 1997, as amended at 63 FR 57559, Oct. 27, 1998; 71 FR 75046, Dec. 13, 2006; 74 FR 51688, Oct. 7, 2009, as amended at 75 FR 27138, May 13, 2010; 79 FR 10313, Feb. 24, 2014]

Subpart B—Requirements Relating to Access and Renewability of Coverage, and Limitations on Preexisting Condition Exclusion Periods

§ 146.111 Preexisting condition exclusions.

(a) *Preexisting condition exclusion defined*—(1) A *preexisting condition exclusion* means a *preexisting condition exclusion* within the meaning set forth in § 144.103 of this part.

(2) *Examples.* The rules of this paragraph (a)(1) are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan provides benefits solely through an insurance policy offered by Issuer S. At the expiration of the policy, the plan switches coverage to a policy offered by Issuer T. Issuer T's policy excludes benefits for any prosthesis if the body part was lost before the effective date of coverage under the policy.

(ii) *Conclusion.* In this *Example 1*, the exclusion of benefits for any prosthesis if the body part was lost before the effective date of coverage is a preexisting condition exclusion because it operates to exclude benefits for a condition based on the fact that the condition was present before the effective date of coverage under the policy. The exclusion of benefits, therefore, is prohibited.

Example 2. (i) *Facts.* A group health plan provides coverage for cosmetic surgery in cases of accidental injury, but only if the injury occurred while the individual was covered under the plan.

(ii) *Conclusion.* In this *Example 2*, the plan provision excluding cosmetic surgery benefits for individuals injured before enrolling in the plan is a preexisting condition exclusion because it operates to exclude benefits relating to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is prohibited.

Example 3. (i) *Facts.* A group health plan provides coverage for the treatment of diabetes, generally not subject to any require-

ment to obtain an approval for a treatment plan. However, if an individual was diagnosed with diabetes before the effective date of coverage under the plan, diabetes coverage is subject to a requirement to obtain approval of a treatment plan in advance.

(ii) *Conclusion.* In this *Example 3*, the requirement to obtain advance approval of a treatment plan is a preexisting condition exclusion because it limits benefits for a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is prohibited.

Example 4. (i) *Facts.* A group health plan provides coverage for three infertility treatments. The plan counts against the three-treatment limit benefits provided under prior health coverage.

(ii) *Conclusion.* In this *Example 4*, counting benefits for a specific condition provided under prior health coverage against a treatment limit for that condition is a preexisting condition exclusion because it operates to limit benefits for a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is prohibited.

Example 5. (i) *Facts.* When an individual's coverage begins under a group health plan, the individual generally becomes eligible for all benefits. However, benefits for pregnancy are not available until the individual has been covered under the plan for 12 months.

(ii) *Conclusion.* In this *Example 5*, the requirement to be covered under the plan for 12 months to be eligible for pregnancy benefits is a subterfuge for a preexisting condition exclusion because it is designed to exclude benefits for a condition (pregnancy) that arose before the effective date of coverage. The plan provision, therefore, is prohibited.

Example 6. (i) *Facts.* A group health plan provides coverage for medically necessary items and services, generally including treatment of heart conditions. However, the plan does not cover those same items and services when used for treatment of congenital heart conditions.

(ii) *Conclusion.* In this *Example 6*, the exclusion of coverage for treatment of congenital heart conditions is a preexisting condition exclusion because it operates to exclude benefits relating to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is prohibited.

Example 7. (i) *Facts.* A group health plan generally provides coverage for medically necessary items and services. However, the plan excludes coverage for the treatment of cleft palate.

(ii) *Conclusion.* In this *Example 7*, the exclusion of coverage for treatment of cleft palate is not a preexisting condition exclusion because the exclusion applies regardless of when the condition arose relative to the effective date of coverage. The plan provision,